RFI Number: 318.65-217

Request for Information

for

Managed Care Organization Serving Middle Tennessee Region

Prepared for:

Bureau of TennCare

Department of Finance and Administration

State of Tennessee

December 12, 2005

WellCare Health Plans, Inc.
The WellCare Group of Companies

WELLCARE OF FLORIDA, INC.

HEALTHEASE OF FLORIDA, INC.

WELLCARE OF NEW YORK, INC.

WELLCARE OF CONNECTICUT, INC.

HARMONY BEHAVIORAL HEALTH, INC.

WELLCARE OF LOUISIANA, INC.

COMPREHENSIVE HEALTH MANAGEMENT, INC.

HARMONY HEALTH SYSTEMS, INC.

HARMONY HEALTH PLAN OF ILLINOIS, INC.

P.O. Box 26022

Tampa, Florida 33623-5735

8735 Henderson Road, Ren 2

December 9, 2005

Alma Chilton
Contract Coordinator
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Ms. Chilton:

On behalf of WellCare Health Plans, thank you for your interest in returning TennCare to a full-risk coverage model in partnership with private health plans. We have prepared a detailed response to your Request For Information (RFI) that conveys both our enthusiasm to support your Middle Region pilot initiative and our capability to do so. This cover letter briefly introduces our company and provides two design suggestions that we believe can maximize the pilot's effectiveness.

Brief Overview Of WellCare

WellCare is the largest Medicaid managed care organization in the southeastern United States. We have extensive experience operating Medicaid health plans in five states, and we are in the process of entering a sixth state, Georgia, on a massive scale. Earlier this year in Georgia, against an unusually competitive field of ten highly qualified bidders, WellCare was awarded one of the largest single-MCO Medicaid managed care contract in the nation's history and was chosen as Georgia's statewide default plan.

WellCare also serves Medicare members in Florida, Louisiana, and New York. In each of these states, as well as in Georgia, WellCare has been awarded Special Needs Plan contracts to serve Medicare/Medicaid dual eligibles beginning in January 2006. WellCare was also awarded a nationwide federal contract to provide Medicare prescription drug coverage; enrollment began in November 2005.

WellCare's entire business involves serving the Medicaid and Medicare populations. Thus, we are keenly aware of the wide array of tailored programs needed to serve high-need populations effectively. As we were able to demonstrate in our Georgia proposal, WellCare offers a particularly strong and innovative set of approaches to addressing the needs of low-income Medicaid populations. In all of the states where we have the privilege of enrolling and serving Medicaid clients, our focus is on succeeding as a long-term business partner on all fronts:

- improving the health status of our enrollees and enhancing their access to needed care;
- creating savings for the Medicaid agency while improving the quality of Medicaid services;
- providing accountability for quality outcomes;
- paying providers fairly and promptly;
- creating local jobs; and
- applying best practices from other markets.

Many of the RFI questions seek information about the unique elements of our programs. While we will be somewhat cautious about detailing all of our innovative features at the RFI stage, we have provided significant information about our existing operations. We are excited about the opportunity to bring our effective and innovative system of Medicaid coverage to the TennCare population.

Program Design Suggestions

We are supportive of the State's intended program design features. In particular, we like the inclusive approach regarding high-need population subgroups, the integration of behavioral health services, and a mandatory enrollment model that permits MCOs to focus their resources on "serving" rather than "selling."

Our greatest concern in TennCare moving to a full-risk model, which we would expect is shared by other Medicaid MCOs as well, is payment rate adequacy. By most accounts, TennCare has been under-funded for several years – striving to cover as many persons as possible but finding that its ambitious coverage objectives have not been aligned with the level of available public funds. Many at-risk MCOs have not found it possible to sustain viable programs. Our key suggestion to ensure actuarially sound rates that are viable for MCOs over the longer term is that TennCare establish rates for the Middle Region rather than soliciting bids. MCOs should be provided full information on the derivation of the rates – baseline costs, trending assumptions, provider prices, administration and risk margin allocations, etc.

Another very important issue is that of the procurement and go-live timeline. MCOs must have adequate time to prepare a thoughtful proposal, establish strong provider networks and operations, and work with the State to ensure the success of the program. This is particularly important for plans that are new to the Tennessee market. By creating too short a procurement timeline, the State might unintentionally restrict the number of bids.

Concluding Remarks

In closing, I want to emphasize WellCare's *high* level of interest in this initiative. We have a demonstrated ability to respond quickly and capably when RFPs are released. We welcome the opportunity to serve additional Medicaid populations, and we hope the ultimate program design will compel us to submit a proposal.

We very much look forward to the opportunity to work with you for years to come, and appreciate your inviting WellCare's input. Please feel free to contact me at (813) 290-6385 at any time to discuss this submission.

Sincerely,

Alec Cunningham
Vice President, Business Development

CORPORATE BACKGROUND AND EXPERIENCE

Please provide the information requested below about your organization.

1. Corporate Information

- Name: WellCare Health Plans, Inc.
- Address: Renaissance One
  8725 Henderson Road
  Tampa, FL 33634
- Telephone Number (813) 290-6200
- Fax Number (813) 490-3977
- E-Mail Address E-mail may be sent directly to the individual responsible for this RFI at Alec.Cunningham@wellcare.com

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

WellCare Health Plans, Inc. is the parent company of eight operating subsidiaries licensed to do business as HMOs in the states of Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, and New York. In this RFI response, we will use the name "WellCare" to refer to the corporate entity and our operations as a whole.

3. State of incorporation or where otherwise organized to do business

WellCare Health Plans, Inc. is incorporated in Delaware, and is publicly traded on the New York Stock Exchange under the trading symbol "WCG".

4. States where currently licensed to accept risk and a description of each license

WellCare Health Plans, Inc. does business in seven states through the following HMO licensed operating subsidiaries:

Table 1. Licenses by State

State	Plan Name	License Type
Florida	HealthEase of Florida, Inc.	Medicaid and Healthy Kids (SCHIP)
	WellCare of Florida, Inc. (f/k/a Well Care HMO, Inc.) (d/b/a Staywell)	Medicaid, Healthy Kids (SCHIP), Medicare Advantage
Illinois	Harmony Health Plan of Illinois, Inc.	Medicaid
Indiana	Harmony Health Plan of Illinois, Inc. (d/b/a Harmony Health Plan of Indiana)	Medicaid and Hoosier Kids (SCHIP)
Connecticut	WellCare of Connecticut, Inc.	Medicaid, Medicare Advantage
New York	WellCare of New York, Inc.	Medicaid, Child Health Plus (SCHIP), Family Health Plus (1115 adult expansion), Medicare Advantage
Louisiana	WellCare of Louisiana, Inc.	Medicare Advantage
Georgia	WellCare of Georgia, Inc.	Medicaid, PeachCare for Kids (SCHIP), Medicare Advantage

5. Contact Information

- Name: Alec Cunningham
- Title: Vice President, Business Development
- Telephone Number: (813) 290-6385
- Fax Number (813) 490-3977
- E-Mail Address: Alec.Cunningham@wellcare.com

6. Program Experience - General

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

WellCare has more than three years of capitated Medicaid experience in five states. Earlier this year, WellCare secured a capitated contract in Georgia through a competitive bidding process.

Table 2. Medicaid Experience by State

State	Years of Medicaid Capitation Experience	Contract Start Date
Florida	11	WellCare of Florida, Inc.: July 1994 - Medicaid; October 2001- Healthy Kids
		HealthEase of Florida, Inc.: May 2000 - Medicaid; October 2003 - Healthy Kids
Connecticut	10	September 1995
Illinois	9	May 1996
New York	8	October 1997 - Child Health Plus; October 2001 - Family Health Plus
Indiana	4	January 2001
Georgia	New contract	July 2005 (Awarded for 1 year with 6 option renewal years; enrollment to begin in April 2006)

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

WellCare currently is not NCQA accredited, although we are pursuing NCQA accreditation in Georgia. WellCare would be willing to pursue accreditation by NCQA in the State of Tennessee within a reasonable period of time after contract award.

WellCare is currently accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) in Florida for all lines of business, and WellCare's internal behavioral health organization is currently URAC accredited.

WellCare has extensive experience with HEDIS and CAHPS reporting. To ensure ongoing quality of care, WellCare calculates HEDIS rates for each of its Medicaid plans on a monthly basis and identifies members who are in need of preventive services. We then outreach to these members and their providers to ensure they receive the preventive care services they need. WellCare utilizes NCQA HEDIS certified software, McKesson's Care Resource Management System, to calculate our HEDIS rates on an annual basis. Each year, WellCare works with an NCQA-certified HEDIS auditor to ensure the reliability of our HEDIS measures across all of our health plans. Each plan then submits its audited HEDIS scores to the State, CMS, or NCQA as required.

WellCare contracts with the Myers Group, a NCQA-certified vendor, to conduct the CAHPS member satisfaction survey in our state Medicaid programs. The Myers Group collaborates with WellCare to evaluate the survey results on an annual basis. WellCare conducts root cause analysis to identify opportunities for improvement in member satisfaction, and to implement corrective action plans to continuously improve member satisfaction.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

WellCare currently contracts with Connecticut, Florida, Georgia, Illinois, Indiana, and New York to provide Medicaid services, as described in Table 2.

7. Medicaid Program Experience - Services

Please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

Table 3 indicates how services are provided in the six states where we have a Medicaid contract. WellCare has experience directly providing or overseeing subcontractors for every service, except long-term care, and provides behavioral health directly to 470,000 members through our Florida Medicaid plans. For those services for which we contract with an external vendor, we have effective subcontracts with extensive delegation and oversight to ensure subcontracted services meet all quality and operational contract requirements. In some states, WellCare also assists with coordination of services that are not covered in the MCO benefit package, such as non-emergency transportation.

Table 3. Provision of Medicaid Services by State

Service	FL	IL	IN	NY	CT	GA
Physical Health Benefits	✔	✔	✔	✔	✔	✔
Dental Benefits	--	--	--	--	--	S
Vision Benefits	S	--	S	S	S	S
Non-Emergency Transportation	--	S	S	--	✔	--
Behavioral Health Benefits	✔	S	S	S	S	S
Pharmacy Benefits	S	--	S	S*	S	S
Long-Term Care Benefits (nursing facility and HCBS)	--	--	--	--	--	--
Home Health	✔	✔	✔	✔	✔	✔
Claims Processing and Adjudication	✔	✔	✔	✔	✔	✔
Quality Assurance	✔	✔	✔	✔	✔	✔
Utilization Management	✔	✔	✔	✔	✔	✔
Case Management	✔	✔	✔	✔	✔	✔
Disease Management	✔	✔	✔	✔	✔	✔
Provider Credentialing	✔	✔	✔	✔	✔	✔
Enrollment Assistance	✔	✔	✔	✔	✔	✔
Member Services (inquiry, ID cards)	✔	✔	✔	✔	✔	✔
Member Grievances/Appeals	✔	✔	✔	✔	✔	✔

* Pharmacy is not covered by MCOs for Medicaid, but is covered for SCHIP and expansion populations
✔ Services are provided directly by WellCare
S Services are subcontracted to an external vendor
-- Services are carved out of the MCO benefit package

8. Medicaid Program Experience - Population

Please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

Table 4 shows each state in which WellCare enrolls Medicaid members, and the current approximate members by each specified population. As of the end of September 2005, enrollment in all states totals nearly 780,000. We also expect several thousand members to enroll in Georgia in 2006.

Table 4. Current WellCare Enrollment By State And Population Group*

Population	FL	IL	IN	NY	CT	TOTAL
Aged, Blind and Disabled (non–duals)	47,000	n/a	n/a	2,000	n/a	49,000
Dual Eligibles	n/a	n/a	n/a	n/a	n/a	n/a
TANF and TANF-Related	351,000	93,000	86,000	50,000	33,000	613,000
SCHIP	72,000	1,000	3,000	11,000	2,000	89,000
Waiver Expansion Population	n/a	n/a	n/a	25,000	n/a	25,000
SPMI**	17,000	***	***	***	***	***
SED**	25,000	***	***	***	***	***
TOTAL	470,000	94,000	89,000	88,000	35,000	**776,000**

* Enrollment in Georgia will begin in April 2006.
** These populations are subsets of earlier rows. Total population therefore does not represent a sum of all rows in table, but does reflect an accurate membership total.
*** As SPMI and SED is a clinical classification, we were not able to determine actual enrollment of these populations within the RFI response timeframe.

9. Medicaid Program Experience – Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

The following chart indicates each state in which WellCare holds a Medicaid contract and the type of financial arrangement in each. WellCare has experience with performance incentives in several states, and would welcome the use of performance incentives in TennCare.

Table 5. Payment Methodology by State

State	Payment Approach	Comments About Incentives or Risk Sharing Arrangements
Florida	Full Risk	No financial incentives
Illinois	Full Risk	If the medical loss ratio is less than 82%, WellCare refunds the balance to the State
Indiana	Full Risk	Financial incentive payment based on attaining a predetermined percentile of HEDIS scores
New York	Full Risk	Financial incentive payment based on achieving target measures for preventive screenings such as breast cancer and retinal eye exams for diabetics
Connecticut	Full Risk	No financial incentives
Georgia	Full Risk	MCOs can receive incentive payment of up to 5% of premium for activities related to the following: EPSDT screening rates, EPSDT follow-up, blood lead screening for infants, children's dental visit rates, newborn notification, and member hotline performance.

10. Experience – Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

This question is not applicable – WellCare currently has Medicaid contracts in six states.

11. Reformed Managed Care Model

A. Behavioral Health

Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced candidates. Thus, both single-entity, "pure play" BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee's physical health and behavioral health conditions.

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

WellCare is responsible for providing behavioral health services in all six of our state Medicaid programs. We strongly believe in the value of an integrated medical and behavioral system of care. Because of our commitment to integration, WellCare established an internal behavioral health subsidiary to provide behavioral health management to our enrollees in 2004. Harmony Behavioral Health, Inc., which we will refer to as WellCare Behavioral, currently manages behavioral health services for all of our enrollees in Florida. We currently use subcontracted behavioral health vendors in Georgia, Illinois, Indiana, Connecticut and New York, but plan to transition our enrollment in these states to internal management in the near future. This will allow us to use a fully integrated medical and behavioral approach that is already successful in Florida.

We provide behavioral health services, as shown in the following table, to the TANF and related populations in all six states, and to the ABD population in two states. Many of our members meet the definition of serious emotional disturbance (SED) and severe persistent mental illness (SPMI). These populations represent a significant number of our members in Florida who receive behavioral health services.

Table 6. Behavioral Health Services by State

Behavioral Health Service	FL	NY	IL	IN	GA	CT
Inpatient	✔	✔	✔	✔	✔	✔
Partial Hospitalization	✔	✔	✔	✔	✔	✔
Intensive Outpatient	✔	✔	✔	--	✔	✔
Community Mental Health Services	✔	✔	✔	--	✔	✔
Intensive Case Management	✔	✔	✔	--	✔	✔
Home Based Services	✔	✔	✔	--	✔	x
School Based Services	✔	✔	x	--	✔	x
Recovery Support	✔	✔	x	--	✔	x

-- Outpatient mental health services are carved out of the MCO benefit package in Indiana.
x These services are not Medicaid covered services in Illinois and Connecticut.

Over the last 30 years, multiple studies have shown that individuals with severe mental illnesses have high rates of physical health related problems, and those with mental illness are more likely to have multiple physical disorders. In a recovery-oriented mental health system, physical health care is as central to an individual's service plan as housing, job training, or education. Recipients of multiple services can best be served when input about their health is gathered, coordinated, and integrated at one central point. One study involving 120 veterans with serious mental illnesses found that those who

received integrated care were more likely to make primary care visits and less than half as likely to have emergency visits.[1]

WellCare Behavioral is well qualified and prepared to manage the behavioral health benefit in Tennessee. We believe an integrated approach to providing physical and behavioral services improves access and outcomes for members, providers, and the State through:

- **improved coordination of medical and behavioral services, resulting in improved health outcomes;**
- **real time access to member and provider data including pharmacy, primary care and pediatric physicians, specialty and ancillary services; and**
- **centralized systems for claims, appeals, member services and provider relations, which eliminate issues of responsibility that typically exist between an MCO and an outsourced BHO.**

An integrated medical/behavioral approach ensures that members and providers are not "caught in the middle" of disputes regarding whether a given service is physical or behavioral, ensuring that members can access services appropriately and that providers are paid on a timely basis. Because of the strong core of public providers in the behavioral health arena, WellCare has found that this approach better meets the administrative and policy objectives of states.

2.Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

WellCare's medical management philosophy is that optimal member health outcomes require significant care coordination among the member, primary care physician (PCP), behavioral health and other health care professionals and the MCO. Many behavioral health crises begin with a medical crisis. Thus, it is essential for the primary care physician to play a central role in coordinating care, so that the relevant history of symptoms, diagnostic testing, and response to treatments is available in one place. WellCare assists primary care physicians by identifying and case managing members whose medical and/or behavioral health needs warrant close monitoring or coordination of care. PCPs are also notified in writing when behavioral health services are authorized. The primary care physician is contacted regularly for clinical insight, medical orders, and exchange of information pertinent to coordination of member care.

WellCare uses sophisticated tools to ensure the best coordination and management of care. Care managers use the McKesson InterQual® Behavioral Health Criteria for making medical necessity decisions, and Perot Peradigm System, an integrated medical management system, to ensure coordination between physical and behavioral health care. Care managers have the ability to review PCP assignments and medical and behavioral health data including recent hospitalizations and services, and pharmacy data. Behavioral care managers meet with medical care managers on a bi-weekly basis to discuss coordination of care in behavioral and medical co-morbid cases, and determine appropriate interventions such as referral to home health, case management, disease management, or high risk case management.

WellCare conducts a number of quality assurance activities to ensure coordination of medical and behavioral care. On a monthly basis, we identify and monitor PCPs who are prescribing anti-depressants

[1] *Get It Together: How To Integrate Physical and Mental Health Care for People with Serious Mental Disorders;* C. Koyanagi, June 2004; Bazelon Center for Mental Health Law.

or atypical anti-psychotics for diabetics, and provide interventions to ensure these medications are being administered correctly. We also perform laboratory follow-up studies for members receiving lithium treatment to ensure members are scheduling routine lab assays and results are reported to the prescribing PCP or provider. WellCare's medical director and other leaders take an active role in ensuring quality of care through participation on advisory committees with community providers and internal meetings to address various care issues. In addition, WellCare promotes provider education by offering seminars on topics of interest and continuing medical education to primary care providers, such as diabetes and depression.

In working primarily with Medicaid members, WellCare Behavioral is experienced in the provision of managed behavioral health care and services to culturally diverse populations, including Hispanic, Asian, and African-American members. Fifty percent of the intake staff are multi-lingual and member referrals are often based on cultural responses and needs. Our behavioral provider network is also culturally diverse; over 50 percent of our providers in Florida are multi-lingual.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

WellCare believes that a coordinated approach for individuals with SED and SMPI will actually improve quality of care for these members by promoting use of appropriate services and ensuring that all health care needs are met in a timely and continuous manner. In our experience, the key to managing these populations is to identify their needs and link them to the services they need. When we enroll members with SED or SPMI, we monitor claims and pharmacy information and communicate frequently and effectively with providers to identify unique needs. Based on what we find, we use case management to link members to community services and coordinate between the PCP and other behavioral services. We then continue to monitor, evaluate, and adjust services as appropriate to ensure ongoing quality of care.

WellCare recognizes that SED and SPMI members are often difficult to reach, and encouraging these members to seek appropriate treatment is the first step in providing effective management of their conditions. Therefore, we have designed an outreach program specifically tailored to target this population and achieve the following goals:

- Obtain quality behavioral health services for our members by increasing access to behavioral health services within their communities and encouraging them to seek needed services.
- Identify community behavioral health care needs and areas that may need increased outreach.
- Educate providers and members about evidence based practices that have resulted in positive member outcomes in similar communities.
- Educate members, health care providers, and stakeholders about changes in Medicaid behavioral health care.
- Increase community awareness of behavioral health disorders and decrease the stigma that surrounds seeking care.

WellCare Behavioral provides outreach services through written communication, site visits, mental health screenings in various locations, psycho-educational workshops and trainings, and community sponsored mental health themed events. Our established network of providers and the WellCare team provide outreach activities designed specifically for the communities we serve. We outreach to members of all

risk levels, providers, local agencies and stakeholders, and advocacy groups. Once members are identified and engaged in treatment, the team works to provide interventions that are tailored to the often unique needs of the SPMI and SED populations.

In-home and other community based services are often the best interventions for the SED population. Children identified as high risk or SED are referred for more intensive services that often include therapeutic behavioral on-site services in the school and/or in the home. WellCare Behavioral often tries to treat SED children in school, in order to more fully assess their strengths and weaknesses and understand their level of functioning with their peers. Treatment approaches are tailored to the specific needs of high-risk children and are provided by a behavioral analyst or, for older children, a cognitive therapist. School and home-based services are the best alternative for families that do not have the organizational structure to comply with ongoing outpatient services provided in traditional office settings. In addition, providing these services within the home and school eliminates transportation barriers common within the Medicaid population.

Psychosocial rehabilitation, with a focus on restoration of a previous level of functioning or improving the level of functioning, is a service that has proved invaluable with these populations. Social rehabilitation and counseling assists in the redevelopment of communication or socialization skills. WellCare Behavioral also has experience with recovery oriented and peer to peer treatment settings, such as the clubhouse model for SPMI adults.

Targeted case management is a key service component used extensively for members with SED and SPMI who require two or more coordinated services to be able to live in the community. Case management is also used for members who have been hospitalized and may be at risk for readmission or treatment noncompliance. Case managers create a service plan based on the specific needs of a particular member, and monitor and coordinate the member's prescribed care.

Many of our SED and SPMI members require intensive intervention in excess of that afforded by the traditional care management review process. To meet this need, WellCare Behavioral has developed a program that focuses on: forecasting member risk; identifying "unstable" cases; developing solutions for problems within the member's system of support and care; coordinating activities across all levels of care to avert the need for hospitalization, re-hospitalization or prolonged intensive behavioral health care services; and improving patient quality of life, function, and life productivity. This program is described in more detail below in the section on disease management.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

WellCare recommends an integrated solution to provision of behavioral and physical health care benefits in which one organization is responsible for all the member's behavioral and physical care. Historically, SPMI and SED members have received services from a different set of providers, funded separately from Medicaid, resulting in poor continuity of care and coordination of services. As a result, members received duplicative services due to poor aftercare and a lack of case management and coordination between agencies and outside programs. Integrating the benefit would give Tennessee greater financial efficiency in serving some of its most needy citizens while delivering added accountability to tax payers.

Network considerations are very important for SPMI and SED members; these members need a broad range of services to ensure their needs are met. Essential services include outpatient services, school-related services, supportive employment, supportive housing, and longer term residential treatment. Members should have access to providers such as community mental health centers and other specialty non-profit agencies that have a broad range of innovative wrap-around services and the expertise to

ensure that the complex needs of SPMI and SED members are met. These populations require a flexible blend of services that are often outside of the traditional behavioral health delivery system of psychiatry, psychology and office-oriented outpatient counseling. Given the complex issues faced by these individuals, services will be ineffective if this population is expected to comply with the demands of regular office visits. Rather, the delivery system must be flexible and able to reach these individuals in their natural environments where they are most accessible. WellCare expects to contract with providers who focus on home and school-based interventions and offer mobile treatment support. Other non-traditional services for SPMI individuals related to housing and employment support also are vital if this population is to be effectively served. WellCare would also increase access to private outpatient professionals in order to offer greater choice and access to members.

Individuals that can benefit from service coordination are often identified through pharmacy usage. Indeed, use of pharmacy data to identify high risk members is a cornerstone of early intervention and disease management. **If pharmacy benefits are to be carved out of the MCO benefit package, it is essential that MCOs receive timely access to pharmacy data.** We also request that the types of pharmacy cost management initiatives occurring under the carve-out pharmacy program be fully described to the applicants. In the behavioral health arena, for example, the degree to which "fail first" or other formulary requirements are imposed (and to which benefits limits on the number of drugs covered at any point in time can be over-ridden) can significantly affect the MCO's care management approach and medical costs. It is also essential that MCOs have a role in ongoing pharmacy formulary or cost containment decisions that will affect overall health care of members, especially those with SPMI or SED. For example, imposing a PDL without "grandfathering" the prescription drugs currently used by these individuals can have detrimental impacts on the member's stability and other health care costs. If WellCare is to be fully at-risk for these members' care outside of pharmacy, it is important that WellCare and other MCOs participate in decision making that might adversely affect our members or their health care costs.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

We believe that excluding individuals with SPMI and/or SED from an integrated health plan would be a disservice to this already marginalized segment of your community. High need individuals across the behavioral and clinical spectrum are those that WellCare can help the most and those for whom the greatest financial savings can be obtained. While we would continue to be interested in bidding, we believe this decision would have an overall negative impact for the State as well as WellCare.

It has been our experience that the highest quality of care and best patient outcomes are achieved when behavioral and medical services are provided in an integrated service delivery system. Excluding SPMI and SED individuals from managed care will increase the likelihood that poorly integrated medical care will result in higher overall healthcare costs for these members.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

As stated above, WellCare would continue to be interested in bidding, but an alternative or shared-risk arrangement would not necessarily increase our interest. The SED and SPMI population require a highly coordinated approach to care, and using an alternative approach may limit the advantages of treating an individual's conditions within one system of care.

While WellCare welcomes the opportunity to care for this population, we understand that there may be hesitations about including this population in the reformed model. We are not opposed to short-term

alternative risk arrangements that would help ease the transition of this population. TennCare could consider having MCOs manage this population's services in a shared-risk arrangement with the State for a one to two year period until the historical patterns of service utilization can be fully incorporated in a managed care model. MCOs could also manage the expanded benefit on an administrative basis, overseeing the fee-for-service system for a similar period of time.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

WellCare understands that community providers are a major source of care for the Medicaid population, and makes every effort to include these providers in our networks. We have experience in contracting and working with Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Critical Access Hospitals (CAHs), Title X clinics, community mental health centers, and other local community agencies and providers that have experience with the Medicaid population.

Community agencies are particularly important in providing behavioral health services to Medicaid members. In Florida, Community Mental Health Centers (CMHCs) provide a complete array of specialized mental health services including therapeutic in-home services, targeted and intensive case management, medication clinics, community outreach, rehabilitation, role recovery and crisis stabilization units for psychiatric and dual diagnosis admits. CMHCs have many years' experience in providing services to Medicaid members and are particularly aware of the social challenges – poverty, homelessness, fragmented families, school problems – associated with this population. Our network includes nearly 100 percent of these centers.

WellCare Behavioral works closely with CMHCs in the care of our members. We are in contact with CMHCs on a daily basis through our case management and care coordination activities. CMHCs also participate in WellCare's quality efforts and audits, such as regular meetings to discuss quality improvement plans and studies, process improvements, new contract requirements, pharmacy interface, utilization management and credentialing audits, and reporting requirements. We have developed incentive contracts with key CMHCs, in which we share financial savings that result from reduction in admission and readmission rates in their respective catchment areas. This program has been instrumental in bringing the CMHCs into the managed care paradigm and reinforcing the value of partnering cooperatively with MCOs. We routinely receive feedback from the CMHCs that WellCare Behavioral is more involved in patient care than any other MCO and that they appreciate the professional relationship they have with us and our staff.

We also contract with many small, not-for-profit agencies, individual providers, and specialty providers, and have an extensive history of contracting with minority business enterprises and faith based community agencies; the current network in Florida includes over fifty minority business enterprises and faith based agencies.

WellCare's ability to form relationships with community providers can also be demonstrated through our recent experience in Georgia. Over the past year, we have contracted with 80 percent of the State's "Significant Traditional Providers," a term used by the State of Georgia to describe high-volume Medicaid physicians, hospitals, and clinics, including behavioral health providers. WellCare is still in the contracting process and expects to have nearly 100 percent of these traditional providers in our network by March 1, 2006.

5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

WellCare's most important recommendation is that the TennCare proposal emphasize the importance of integrating the behavioral health benefit with the medical benefit. The greatest advantage in having a fully integrated behavioral and medical model is the consistency and agreement in scope of services, treatment planning, outcomes measurement, and quality initiatives. MCOs must ensure the coordination of care and intervention at the PCP level, allowing for immediate treatment of co-morbid disease states, continuity in the treatment regimen, coordination of medical treatment and medication compliance, and aftercare coordination. In this model of centralized care management, a single case manager coordinates the member's care across all disciplines, ensuring that all of the member's medical and behavioral conditions are being addressed in the most appropriate setting. Use of a single IT system also provides for real-time access to a member's medical course of treatment, which is critical given the transient nature of this population and the need for aggressive follow-through at every stage of treatment and recovery.
Access to real time data is also a key consideration, especially if pharmacy benefits are carved out of the MCO benefit. Pharmacy is a key treatment component in behavioral health services, and a carved out benefit may cause some overall care coordination challenges.

WellCare also recommends that behavioral health capitation rate methodologies and benefit details be presented to the MCOs in order to better understand the historical service issues and challenges going forward. We would welcome accepting medical risk for these services, given that actuarially sound rates can be established for these services and appropriate risk adjusters are used for these high need subgroups. As stated earlier, TennCare could incorporate a shared risk contract structure or a stop-loss provision in the first two years of the new program as a form of financial guarantee to new MCOs. These provisions will provide added financial certainty until the MCOs have the necessary experience with the current systems of care and the appropriate full risk capitation rates can be derived.

B. Pharmacy Services

Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.

WellCare requests a daily download from the PBM's claims system, to support our care management programs on a timely basis. Based on the comments provided at the December 1 pre-proposal conference, it does not appear that TennCare staff will revisit whether or not to carve out prescription drugs at the present time. While we understand the State's position (and in fact have our own set of TennCare-specific concerns about how "manageable" the pharmacy benefit will be under the various legal constraints that exist), we do encourage that State officials still consider the possibility of carving the pharmacy benefit into the Middle Region capitation pilot program after it is implemented.

Most states, for both cost and quality reasons, have opted to include pharmacy in their capitated programs, and objective studies have confirmed this to be the most cost-effective design.[2] Under the carve-out, WellCare will use the pharmacy data regularly (typically, on a daily basis) in our efforts to identify high-risk patients and to support our various case management and disease management programs. In conducting these activities in the most timely manner, it is important that we have immediate access to the PBM's pharmacy claims data.

From a program design perspective, we also encourage that the RFP for MCOs fully describe how the pharmacy benefit will be administered. The degree to which limits on the number of drugs covered are rigidly adhered to versus over-ridden, for example, can have significant implications for our enrollees (and can put some enrollees at high risk for costly flare-ups to occur whenever access to medications is being limited). The use of "fail-first" requirements can also be clinically ineffective for many persons, with this adverse scenario often being played out in the behavioral health arena.

Another general issue with carve-outs is the potential for each party to manage its own "turf" to the detriment of achieving overall cost savings. It may be useful to convene regular meetings between TennCare, its contracted PBM, and contracted MCO staff to discuss and address operational issues that are arising related to the pharmacy carve-out model.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

As noted above, WellCare will seek daily access to (or downloads from) the PBM's claims system. We request that any downloads be provided in a NCPDP 5.1 format. Such access will enable us to promptly identify prescription drug usage issues/changes that feed into case identification and intervention adjustments, and are important components of our disease management, case management and behavioral health management programs. Pharmacy data will also be used to identify providers that will be placed in utilization management programs.

C. Long-Term Care Services

Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package. However, individuals receiving long-term care services (including the aged, blind and disabled population) will be enrolled in MCOs for their acute and behavioral health services.

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.

In a carve-out model, WellCare uses a medical /social framework to coordinate acute care and long-term care services. In particular, long-term care requires a fully integrated case management program which incorporates complex medical, social, and therapeutic needs. All efforts are made to keep the member with the same vendors and coordinate with the appropriate long-term care providers. WellCare also strongly believes in a proactive approach to promote community based services. Our goal is to ensure that members receive the right services, at the right time, in the right place.

[2] One development in this regard worth keeping an eye on is that the United States Senate has just passed a bill that will give Medicaid MCOs access to the same rebates that Medicaid FFS receives. If this bill is approved by the Conference Committee, the case for a pharmacy carve-in will strengthen.

WellCare uses a closed loop, comprehensive case management methodology that consists of the following four activities:

1. **Early member identification** – work with the State to define simple, easy to extract codes which will flag members who receive long-term services. Example techniques include an indicator on the enrollment file, a pre-defined eligibility segment code, or codes that show dollars paid to provider types. Alternatively, we can "data mine" a claims extract file for CPT codes, prescriptions, durable medical equipment, and other relevant data.
2. **Conduct a health risk assessment** – meet with members in person or through an outreach telephone call to collect a basic assessment of their long-term care service needs. Create a member profile using the claims data and member responses to target health risk assessment questions. This profile will answer four basic questions:
   - What services is the member receiving?
   - Why are those services needed and for how long?
   - What additional services are necessary?
   - What is the availability of providers to deliver such services and in what setting?
3. **Identify gaps and resources** – determine what needed services the member is not receiving and arrange for those services. Identify community service gaps and locate resources to help meet those needs, or arrange for alternative methods of service provision.
4. **Communicate with PCPs** – send a report to the member's PCP that the provider can reference during the member's subsequent visit. Such a report contains detail about a member's need for community services, additional recommended services, and a directory with reference to local community services.

2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

The simplest incentive model to encourage use of home and community-based services is to carve long-term care services into the MCO benefit package. If MCOs are at risk for these services, then they have a built-in incentive to use the least costly setting that provides quality care, which in most cases is home and community-based care. However, this model requires an adequate investment in identifying and coordinating acute and home and community-based LTC services. We encourage TennCare to make this investment (in terms of ensuring these services are funded in the capitation rate) even though a short term return on this investment may be minimal. Long-term care savings tend to be modest in the short run but increase significantly in the Medicaid program's favor over time.

Given that full capitation of long-term care services may not be achievable in the near term, we also encourage the State to consider development of bonus payment mechanisms or other financial incentives that reward MCOs for successfully diverting nursing home eligible patients to lower-cost settings. The monthly number of new nursing home admissions is readily quantifiable, for example, and could be used as one means of measuring the success of MCO diversion efforts.

Coordinating acute and long-term care services requires a high level of information sharing and ongoing management that is best provided in a fully-integrated system of care. WellCare recommends that TennCare consider carving long-term care into the MCO benefit package.

Having one entity provide and manage all services will be the most effective way to reduce gaps and duplications in services, and to align incentives to maximize savings. Members with both long-term and

acute care needs will benefit significantly from all-inclusive case management. Currently, members with chronic care or long-term care needs must often seek services and supports from several different services providers. By integrating long-term care and acute care services, WellCare will use our case management system to assist families in navigating the maze of needed services, linking primary, acute, long term care, and social support services.

D. EPSDT Incentives

As part of the TennCare Middle Region reform the State is focusing efforts on enhanced EPSDT screening rates and compliance with the periodicity schedule. The State is considering the use of incentives to reward MCOs that achieve specific targets.

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

WellCare works closely with pediatric providers, parents, and the community to ensure that our members are encouraged to receive all scheduled EPSDT screenings. WellCare staff inform members about the availability and importance of EPSDT services, reach out to members to reinforce the need for these services, and track EPSDT utilization rates. WellCare case managers are available to conduct outreach, provide information on WIC and EPSDT, and make appointments and arrange for transport when needed. In addition, WellCare understands that a key purpose of EPSDT is to identify conditions that need further treatment and connect members with needed services.

In order for WellCare's program to be effective, we inform members of how they can access these services and remind them that they are provided at no charge. WellCare also takes proactive steps to encourage our providers to participate in the EPSDT programs and to ensure compliance with EPSDT screens in all of its Medicaid programs, including the use of physician incentives in two states.

Outreach and Education

WellCare uses a combination of written, audio, and web-based material, telephone contacts, and face-to-face encounters to provide critical information to members on EPSDT at the time of enrollment and throughout their participation with WellCare. The importance of health screens and follow-up treatment is emphasized, and the EPSDT program is explained. Instructions are given as to how members can obtain preventive and expanded services and the role of the PCP. WellCare continues to reach out to members throughout their enrollment to reinforce the need for well-child care and to assist members in obtaining these services. Key informing and outreach activities include:

- **Enrollment and orientation**. All enrollment and orientation presentations include information on EPSDT and the importance of receiving scheduled screenings. New member packets include a member health status self-assessment form to help identify children's current immunization and check-up status. New members also receive a welcome call from a customer service associate within a week of enrollment to introduce WellCare, to encourage participation in preventive programs such as EPSDT, to make sure the member understands the PCP concept and how to contact the PCP, and to answer any questions the member may have.
- **Initial PCP visit scheduling**. WellCare sends written information to members about EPSDT services within 60 days of enrollment and encourages them to schedule a visit with a PCP. Members are sent a letter outlining the preventive services recommended if they have not been seen within 45

days of enrollment. WellCare also coordinates appointments for care and follows up with families with EPSDT-eligible children that have failed to access EPSDT screens and services after 120 days of enrollment. WellCare provides a monthly list to each PCP of the PCP's EPSDT-eligible children that have not had an encounter during the initial 120 days of enrollment.

- **Written/audio-visual materials**. WellCare's member handbook, provided at the time of enrollment, is our key written means of informing all new members about EPSDT services. WellCare also conducts videotape or personal presentations during enrollment and orientation sessions that provide information about benefits, including those of EPSDT.
- **Customer service**. WellCare's customer service department plays an important role in providing information on EPSDT to our members. Each time a member calls with an issue involving a child, our representative uses that opportunity to reinforce the member's understanding of the importance of well-child care and the services available through EPSDT. WellCare representatives also are trained to determine whether the child has had an appointment within the appropriate time interval and assists in scheduling an appointment if needed.
- **Informational activities for pregnant women**. WellCare recognizes that reaching pregnant women with information about EPSDT services is important in ensuring healthy babies and healthy children. WellCare also uses other means to inform pregnant women of EPSDT services. Our perinatal coordinator or case manager discusses preventive and routine care expectations for children during their contacts with pregnant members. The coordinator or case manager also assists members in choosing a PCP for the unborn child and scheduling an initial appointment.

Physician Incentives

In order to encourage PCP participation in the EPSDT program and compliance with EPSDT screening requirements, WellCare provides ongoing education about the importance of the program, offers features on program participants in newsletters, and sends monthly notices to providers about members who are not in compliance with periodicity schedules. Locally based outreach staff support providers by providing outreach to non-compliant patients and helping members overcome barriers to accessing regular care for their children. In addition, WellCare makes an additional payment to providers in New York and Connecticut for providing preventive care services to children and adolescents. This financial incentive is further encouragement for providers to facilitate important health screens.

EPSDT Monitoring

WellCare strives to maintain high levels of EPSDT utilization in its programs. We use claims data to regularly examine EPSDT utilization rates and to track the number of screens each month. The data are then used to monitor overall provider performance and implement additional provider and member interventions to improve compliance. Annual HEDIS measurements also include well-child visit rates and help to show trends in care from year to year. Providers are given monthly reports that show specifically which patients are not in compliance with preventive care scheduling guidelines. Providers and WellCare outreach staff will then encourage parents to bring children in for required screens.

WellCare also monitors provider compliance with screening requirements through annual medical chart audits. Individual PCPs who do not meet the threshold for standards of clinical preventive pediatric care are notified and a corrective action plan is developed. Information from the chart audits also is used as part of the routine annual quality improvement planning process. For example, the plan may determine whether additional measures should be added to the list of profile measures, or whether it is appropriate to distribute provider profile reports to additional provider types such as dentists.

Recommendations for Enhanced EPSDT Incentives

WellCare recommends TennCare use an enhanced incentive for EPSDT as a way to promote these essential services. However, we feel that an appropriate target screening rate should be set according to current statewide screening rates. Timing is also important; we feel our outreach and educational methods are effective, but population-wide changes take time. If the current statewide screening rate is much lower than 80 percent, it may make sense for MCOs to be rewarded for incremental improvements over time. Incentives could also be provided for other activities that support EPSDT services. In Georgia, MCOs can receive an incentive payment of up to 5 percent of premium for meeting various program goals, including achieving an EPSDT screening rate in excess of the minimum compliance rate, as well as following-up with members who have not received scheduled EPSDT screenings. TennCare might consider using these kinds of incentives, which promote outreach and help to increase screening rates over time.

E. Utilization Management/Medical Management (UM/MM)

Essential to controlling the current rate of TennCare expenditure growth is a comprehensive and successful utilization and medical management program. As described above, Tennessee intends to have service limits for various benefits, and the MCO will be responsible for managing care within those limits. The proposal currently before the Federal government would allow the State to implement "hard" benefit limits. The only exceptions would include services on the "short list", which would not count toward benefit limits and continue to be available to enrollees after benefit limits are hit. However, the State is considering moving toward "soft" benefit limits in the future, where services beyond the benefit limit could be provided as cost-effective alternatives to covered services. The MCO would have the lead role in deciding whether to provide services over the applicable benefit limits. The State expects that these services would be authorized using a prior authorization process.

1. Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.

We have found in our experience that the benefit package in Medicaid programs is often more generous than a commercial product. There are relatively few "hard" limits in the states we operate in. WellCare recommends that TennCare avoid the use of "hard" limits, as we believe that having more benefit freedom actually promotes the use of cost-effective care by allowing an MCO to determine the most appropriate care and setting. WellCare has extensive experience in managing care with "soft" limits through utilization management, including prior authorizations, concurrent review, and retrospective review. We also use benefit substitution as a way of managing care within established limits without denying needed services to members, and recommend that TennCare allow substitutions if benefits are limited.

In Florida, for example, inpatient hospital services are limited to 45 days. In order to manage a member's care within the established limits, WellCare feels it makes medical and financial sense to use a skilled nursing facility (SNF) in lieu of a hospitalization when appropriate, even though SNF services are not technically covered under the MCO benefit package. We therefore cover these services, but do not apply any SNF days towards the inpatient limits. In effect, members have access to more care, as up to 45 days of inpatient care is still available if needed. At the time of hospital pre-authorization, members are evaluated to determine if a SNF is the most appropriate setting of care; if so, a prior authorization is used to authorize SNF services instead.

Physical therapy and occupational therapy are limited by number of visits or age in some of our state contracts. WellCare uses prior authorization as a means to determine medical necessity and reviews the cases to see what the impact would be if the member does not receive the services. In many cases, short term rehabilitation can assist the member to return to their normal activities of daily living and prevent re-admissions. If so, WellCare authorizes continued use of these services beyond the benefit limits.

If TennCare were to implement a system of "soft" limits, WellCare would use a case-by-case prior authorization process for use of services beyond the limits. The member would be evaluated by nurse reviewers using InterQual and Medicaid and Medicare guidelines. The nurse reviewers would be able to approve the benefit according to these guidelines, but only a physician would be able to deny services.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

WellCare would recommend "soft" limits for physical therapy, speech therapy and occupational therapy, as need for these services is often member specific. WellCare would be able to decide through medical review if use of services above the limit would be of benefit to the member.

Other use of "soft" limits would be in preventive programs that TennCare would like all MCOs to offer. For example, if MCOs are required to offer a smoking cessation program, pharmaceutical smoking cessation products should be covered more than once, as it is well known that first attempts to quit smoking often fail.

F. Disease Management

Physical Health

The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the expectation would be that the MCO apply disease management techniques to the following physical health conditions:

- *Diabetes mellitus*
- *Congestive heart failure*
- *Coronary artery disease*
- *Asthma*
- *Chronic-obstructive pulmonary disease*
- *High-risk obstetrics*

1. Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs? Again, if yes, on which conditions does your program focus today?

Of the six diseases identified by TennCare, WellCare currently offers disease management programs for four of these diseases – diabetes, congestive heart failure, asthma, and high-risk pregnancy – in all six states where we enroll Medicaid members. In addition, we have a robust case management program for members with any of the following conditions: HIV/AIDS, elevated lead levels, high-risk pediatric conditions, wounds, transplants and all catastrophic illnesses. WellCare is prepared to include TennCare members in our already established and successful disease management programs. Based on our experience in developing these disease management and case management programs, we are well equipped to develop disease management programs for TennCare to serve members with coronary artery disease and chronic-obstructive pulmonary disease.

WellCare began these disease management and case management programs after data analysis and clinical experience demonstrated a need for coordinated member interventions for these conditions. The programs, which were developed in collaboration with network providers, are designed to strengthen the ability of primary care providers, specialists, and members themselves to avoid adverse clinical outcomes and improve overall health for members with one or more of the targeted conditions.

2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

All of WellCare's disease and case management programs are conducted internally by WellCare staff, with the exception of neonatal intensive care unit (NICU) births. WellCare uses qualified staff with clinical expertise to administer and manage its disease and case management programs, as described in more detail in the next section.

WellCare uses a vendor, Paradigm, to provide care management for infants requiring care in the neonatal intensive care unit (NICU). WellCare subcontracts with Paradigm to manage inpatient NICU births on a case rate basis. Paradigm's evidence-based care management approach helps infants reach milestones sooner and transition home smoothly. Paradigm estimates length of stay based on the Grouper System, which is a proprietary methodology used to risk-adjust neonatal populations for overall severity of illness. Through review of cases WellCare has found that the NICU case management program has resulted in a 15 percent reduced length of stay and a very low rate of unplanned readmissions of only 1.1 percent.

To ensure coordination with Paradigm, WellCare stays in close communication with Paradigm staff and monitors case progression and outcomes. Paradigm provides superior access to case information through a secure, user-friendly website, which we can access for daily updates to current cases. We can also readily contact the nurses involved in the case by phone.

3. Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?

Member Identification and Enrollment

Identification of members varies according to the targeted conditions, but follows the same general approach. Members may be referred to the disease management program by case management or utilization management staff, providers, or by the patients themselves. In addition, WellCare proactively analyzes claims and encounter data, inpatient census reports, and authorization requests on a monthly basis to identify members who may have targeted conditions. Claims history, lab values, prescription drug utilization, and clinical decision making by the disease management nurse are all used to stratify the members into levels based on the severity of their disease. The highest priority is placed on members with recurrent hospitalizations and ER visits.

Once members are identified and stratified based on the severity of their disease, they are automatically enrolled in the disease/case management programs. Members can opt-out of the program at any time by calling the Disease Management Program.

Member and Provider Approaches

The Disease Management Program uses a variety of member and provider interventions to promote access to care, educate the member and provider about appropriate treatments, reduce the severity of the patient's condition, and prevent unnecessary hospitalizations or acute episodes. All members receive educational mailings directly related to their disease and the opportunity to request additional information. Members at the highest risk and those who seek additional information will receive outbound telephonic assessments and education by a Disease Management Registered Nurse. Providers receive CME credit for related education and receive clinical practice guidelines for the focused diseases. In addition, providers receive regular updates on their members enrolled in the disease management program who are not seeking adequate care or are not receiving appropriate medication or other services.

The following table provides detail on WellCare's disease management approach. These member and provider interventions are used for all our disease management programs. Members with severe conditions that need a greater level of services and care coordination, considered Level 4, receive case management services.

Table 7. Disease Management Approach

Risk Level	Member Interventions	Provider Interventions
Level 1	• Member mailings • Educational letters • Periodicity schedules • Flu shot reminders	• Introductory letter with program description and enrollment guidelines • Monthly Membership Lists for members in disease management who have not seen their provider in three months • Educational CME inservices • Clinical practice guidelines
Level 2	**Level 1 interventions, plus:** • Telephonic interventions • Disease Risk Assessments • Peak flow meter mailing • Glucometer mailing • Outreach worker home visits	**Level 1 interventions, plus:** • Fax Alerts (e.g., for asthma: patients who have had 4 or more prescriptions for rescue inhalers who have not had a prescription for an inhaled corticosteroid)
Level 3	**Level 2 interventions, plus:** • Increased follow-up phone interventions, including emphasis on disease-specific action plans and self management	**Level 2 interventions, plus:** • Fax Alerts (e.g., readmitted patients within 90 day timeframe, >1 ER visit within 90 day timeframe) • Recommendation for initiation of specific treatments
Level 4	**Level 3 interventions, plus:** • Referral to Case Management	**Level 3 interventions, plus:** • Referral to Case Management

Whereas disease management focuses on education, outreach, and patient self-management, case management takes a more active role in the care received by an individual. Case management focuses on member stability and achievement of short and long term goals, based on clinical guidelines. A primary goal is to prevent ER visits and hospital re-admissions. Any member that has a catastrophic illness or needs highly coordinated care can receive case management services, even if there is not a disease management program for that condition.

Enrollment and Staffing

WellCare currently has a total disease management enrollment of 39,300 members for asthma, 27,000 for diabetes, and 6,300 for congestive heart failure. Members with qualifying conditions may opt out of the program, but currently less than 1 percent of eligible members do so.

WellCare's disease management and case management programs are staffed by registered nurses (RNs) with specific experience in the disease(s) they manage. We ensure that staffing levels are sufficient to manage all members considered a Level 3 risk or higher. These members are at most risk for complications from their conditions and hospital re-admissions.

Disease Management Outcomes

Through our disease management programs, WellCare aims to improve the quality of life of our members, improve health outcomes, and decrease medical costs. The tables below show some of the improvements in care that WellCare has achieved in Florida during the past several years through disease management and other interventions.

Table 8. Florida Medicaid and SCHIP:
Rate of Eye Exams for Members with Diabetes

WellCare Plan	2000	2002
HealthEase (Medicaid)	5%	28%
StayWell (SCHIP)	15%	33%

Table 9. Florida Medicaid and SCHIP: 2003 Readmission Rates

WellCare Plan	Members with Asthma		Members with CHF	
	Benchmark	With DM	Benchmark	With DM
HealthEase (Medicaid)	14.6%	4.5%	27.3%	25.2%
StayWell (SCHIP)	13.1%	5.1%	30.1%	18.9%

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions:

- *Schizophrenia*
- *Bipolar disorder*
- *Major depression*
- *Co-occuring mental illness/substance abuse*

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

Yes, all of WellCare's current programs include care management for behavioral health conditions, including care management for members with schizophrenia, bipolar disorder, and major depression, as well as those with co-occurring mental illness/substance abuse.

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

Behavioral health care management for the TennCare program will be performed within the WellCare organization by our behavioral health specialty company, Harmony Behavioral Health.

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

WellCare has extensive expertise in care management for members with significant behavioral health conditions and has developed a specialized and intensive care management program for members with the most complex and chronic conditions. Our High Risk Care Management Program (HRCM) focuses on identification of members at risk for hospitalization and members with a history of multiple hospitalizations and noncompliance with their outpatient treatment plan. Members with diagnoses of schizophrenia, bipolar disorder, and major depression are prominently included in this program, with care management approaches and interventions specifically targeted to each diagnosis. More than 40 percent of members enrolled in the HRCM program have co-occurring mental illness/substance abuse disorders. The goal of behavioral health care management is to promote the recovery and resiliency of members by reducing the number and duration of intensive services. Key components of the behavioral health care management program are outlined below.

Member Identification, Outreach, and Care Management Approach:

Members are referred based upon their history of intensive service patterns including hospitalization and readmissions (at least 3 admissions in past 90 days) by our medical and behavioral health medical directors and care managers. Members also are identified at enrollment from health risk assessments, reviews of pharmacy reports and members receiving significant psychotropic prescriptions, and by family member referrals.

Upon referral, care managers review members' medical records, pharmacy claims histories, customer service logs, and other available documents. Care managers then formulate interventions specific to each member with the goal of enhancing treatment and medication compliance.

The care manager initiates contact with members, family or supportive acquaintances, and providers. This often first occurs prior to or immediately following an inpatient discharge. Care managers continue to monitor members weekly, or more often if needed, to assess the ongoing treatment status, encourage use of outpatient resources, and provide contact names and numbers to assist in obtaining access to medications, employment, housing, and other social services.

WellCare emphasizes the importance of contacting family members and/or significant others by telephone and in person. Care managers provide education and support regarding the importance of medication and ongoing treatment as well as assistance in navigating around any barriers to service delivery.

On an ongoing basis, care managers monitor pharmacy claims regularly to determine if prescriptions are refilled on a regular basis. In addition, care managers monitor for hospital readmissions and, if needed, provide pertinent information to hospital providers and participate in aftercare treatment planning.

Additional outreach activities are focused on PCP contacts to ensure the identification and early treatment of behavioral health conditions. In addition, outreach and education are conducted at schools, neighborhood social agencies, community housing locations, and in other public forums to ensure that members are aware of behavioral health service availability.

Approach to Co-morbid Mental and Physical Conditions

WellCare has developed a Mixed Services Program to integrate the care management functions of medical and behavioral health. Members with co-morbid conditions may be identified by medical or behavioral care managers through regular care management interactions or from reports designed to identify members who are being treated for both significant medical conditions (e.g., heart disease, asthma) and behavioral health problems (e.g., schizophrenia, attention deficit disorder). Referrals to the Mixed Services Program include:

- Members involved with medical case management where psychiatric issues are identified.
- Members with chronic mental illness and identified ongoing medical conditions affecting their stability, including: heart disease, asthma, eating disorder, diabetes and pregnancy where there is a risk for complications (i.e. HIV, preterm labor, insulin dependence, very young teens (14 years or younger), and hypertension.

Behavioral care managers meet regularly with the medical case managers to discuss referrals, and review interventions, treatment progress and barriers, and pharmacy complications and side effects.

Staffing

WellCare's behavioral health care management program is staffed by a team of care managers with a range of certification, including Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), Psychiatrists (MD), Psychologists (PhD), and Registered Nurses (RN). Staffing levels are designed to meet the needs of members enrolled in the behavioral health care management program.

Provider Involvement and Clinical Guidelines

WellCare employs an active approach to influencing provider behavior through educational interventions including fax alerts, letters and phone calls. Fax Alerts are sent to PCPs of members with major depression. Provider education also is enhanced through periodic presentations, CME offerings, and WellCare sponsored workshops.

We have also adopted a number of best-practice, evidence-based guidelines for behavioral health including: the American Psychiatric Association's *Treatment of Patients with Major Depressive Disorder and Treatment of Patient's With Schizophrenia* as well as the American Academy of Child and Adolescent Psychiatry's *Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder*. These clinical guidelines are distributed to providers and promoted in newsletters and on the WellCare website.

Description of Measurable Outcomes Resulting from Management Interventions

WellCare through its Quality Improvement Program uses several different indicators to measure outcomes of our care management interventions. The HEDIS anti-depressant medication management measurements are used to determine outcomes of our depression interventions. In addition, the HEDIS indicator measuring access to aftercare services following inpatient care also is monitored. At the member level, functional assessments are conducted throughout the treatment process to assess the member's clinical status and symptom severity across a number of clinical indicators. Case management outcomes also are routinely measured by monitoring members' overall health service utilization and behavioral health readmission rates. As another important component of our outcomes program, WellCare conducts patient satisfaction surveys on a regular basis.

G. Capitation Model

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.

WellCare has vast experience in managed care Medicaid markets using risk contract capitation. Five states are currently served on this basis and we are currently entering a sixth state, Georgia, on a large scale. WellCare is comfortable with full-risk contracting whereby we are able to implement a fully integrated system of coverage for our enrollees. This financial structure fosters the most favorable impacts on health status and claims cost levels, and provides predictable cash flows to both the State and to the participating MCOs.

In considering the TennCare opportunity, we will of course need to assess payment rate adequacy and actuarial soundness. Given the challenges the TennCare program has historically experienced with MCO viability, WellCare strongly recommends that capitation rates be derived "out in the open" by the state and its actuaries (as opposed to competitively bid). We request that the following information be provided to all applicants:

- a databook delineating the program's recent cost experience in the Middle Region, including at least two full years of usage and unit costs by type of service (including behavioral health) and capitation rate cohort and (including any estimates of completion factors);

- description of the provider payment rates and methodologies currently used by MCOs in the Middle Region;
- disclosure of any standardized reimbursement methodology such as State fee schedules that are required or recommended for the purpose of in-network provider contracting;
- disclosure of any policies governing payments to out-of-network providers (if no such policies exist, we recommend that TennCare establish an amount that is the MCO's responsibility to the provider in an out-of-network situation, both for purposes of promoting network participation by providers and to avoid costly haggling over the amount owed for each out of network claim by all involved parties);
- for any situations where Medicaid provider payments are tied to provider charges, please provide guidance on the methodology of Cost to Charge Ratios used, including initial ratios and guidelines for any limits on the degree to which applicable charges can be increased;
- all estimates that have been prepared to cost out the value of changes in the population and benefits packages (e.g., imposition of benefit limits) served between the base period and the proposed contract period;
- all estimates that have been prepared to cost out the value of changes in various consent decrees (e.g., which provisions has the Circuit Court reversed and what is the projected cost and usage impact of each change?);
- the trending assumptions made to translate base period costs into actual payment rates, including evidence of the actuarial soundness of these assumptions;
- disclosure regarding any premium tax adjustments, fees, rebates, or risk sharing arrangements to be contributed or shared with the State or other entities; and
- clear indication of the renewal rating process is in place and disclosed to plans so that WellCare can adequately plan for renewal activities and provide an opportunity for discussion with the State regarding requirements for future rating periods.

The more forthcoming the TennCare Administration can be in this critical area, the greater the likelihood that its procurement can attract successful and experienced Medicaid managed care organizations such as WellCare that are seeking a viable long-term partnership. **In TennCare's situation, other rate-setting approaches, especially having the health plans bid into an undisclosed rate range, would seem to place too strong an emphasis on trying to maximize short-term Medicaid savings, and too little emphasis on creating a successful and lasting partnership with the strongest possible MCOs.**

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

As stated above, WellCare has experience in the Medicaid managed care market where full risk capitation is utilized and would have interest in participating in an RFP process for a full-risk program provided the contract provisions and capitation rate development process are reasonable and acceptable to WellCare.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)

We do not recommend this type of risk-sharing be mandated, although perhaps it would be useful to offer MCOs the option of purchasing individual stop-loss coverage from TennCare (in the form of a reduced premium). WellCare believes that we can significantly lower both the incidence of high-cost cases (e.g., through managing high-risk pregnancies in a manner that reduces the number of low-birthweight infants) and the costs of high-need members (e.g., through our disease management and case management interventions). Therefore, we do not wish to see the costs at the high end of the individual cost spectrum "carved out" of the capitation rates as this is an area where WellCare can achieve significant savings on an at-risk basis. Also, we have exceptional overall financial wherewithal to weather extreme, high-cost cases and have no need to avoid this corridor of risk.

b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)

We do not recommend that these types of provisions be included in the program design. Such benefits limits create an administrative burden for all parties. Also, as noted above, well-run MCOs can achieve significant savings by preventing and effectively managing high-cost cases. It is not in WellCare's (nor interest (nor the best interests of the State) to avoid having MCOs take risk in these corridors.

c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)

We would be open to a balanced aggregate risk-sharing corridor, whereby MCOs could neither experience windfall gains nor massive losses. However, such approaches can create some odd incentives (e.g., MCOs paying providers extra amounts to avoid returning funds to the state, etc.). If the capitation rates are set accurately up-front using the "full disclosure" approach recommended above, there is not likely to be much need for complex and administratively costly risk-sharing provisions to be implemented. Current per capita costs already reflect a managed setting where enrollees are linked to a primary care physician and are channeled to a specific provider network. While there are still issues to consider regarding the degree to which new MCOs might be more effective in managing care (and whether all MCOs will be more aggressive/effective in promoting health and managing care once they are at full risk), there may be less uncertainty in this rate-setting situation than often exists when a Medicaid agency procures new MCO contracts.

d. Other

With regard to the rate cells themselves, WellCare encourages the State to establish separate payment rates for all key eligibility categories where substantial cost differences exist with the traditional age/sex distinctions that are typically made. It seems particularly important that the expansion population be separated from other rate groups, and that careful rate-setting impact consideration be given to any policy changes that involve restricting or liberalizing eligibility in any aid category versus the criteria that were in effect when baseline costs were tabulated.

We also encourage separate payments – outside the regular capitation structure – for newborn births. Ideally, this would have two components: 1) a separate "kick payment" for the mother's delivery-related costs, covering the inpatient and OB/GYN services associated with the delivery; and 2) a "first month of

life" rate cell for the infant, which would cover the newborn's hospitalization and related physician services. Most states now use this structure in their Medicaid managed care programs, finding that they are able to actuarially derive these rates in a budget-neutral manner. This risk adjustment is valuable for MCOs, given that they may experience very different birth rates (due to either their demographic or provider network compositions). These adjustments have the effect of substantially lowering the "regular" PMPM capitation rate for females of child-bearing age. In the pediatric categories, it is common to see separate capitation rates for the first month of life, months 2-12, years 1-4, then years 5-14. These pediatric cells typically require no gender adjustment. We have found that boys in these cohorts are slightly costlier than girls on average, but it is extremely unusual for there to be a significant skewing of the gender mix among MCOs child enrollees.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

WellCare would recommend ensuring minimum enrollment in each participating health plan of 100,000 members. Such a minimum enrollment will provide a credible risk pool and help ensure ongoing economies of scale to each MCO. To accomplish this minimum for each plan, WellCare suggests limiting the number of contract awards, which the State is already planning to do, and implementing maximum enrollment thresholds. For example, the State could limit enrollment in one MCO to a specific percentage of eligible members, to ensure that the other MCO has a sufficient enrollment to maintain its risk pool. Limiting the number of MCOs also reduces the State's administrative burden and leverages savings by distributing each MCO's fixed administrative costs across a broad enrollment base.

H. Data and Systems Capability

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

WellCare has a vast reporting capability and can produce encounter data and desired reports in all of our operational areas. Following are types of reports we submit to every state with which we contract on a periodic or ad hoc basis:

- Member information
- Telephone and internet activity
- Eligibility and enrollment reconciliation
- Prior authorization and pre-certification
- Claims processing
- System availability and performance
- Medical loss ratio
- EPSDT
- Timely access
- Provider complaints
- FQHC
- Utilization management
- Quality oversight committee
- Fraud and abuse
- Grievance system
- Cost avoidance
- NAIC quarterly report/income statement
- Performance improvement projects
- HEDIS measures
- Focused studies
- Patient safety
- Systems refresh plan
- Utilization management analysis
- NAIC annual report, audit, income statement
- SAS 70
- Disclosure of annual business transactions
- Provider network adequacy and capacity
- TPL and coordination of benefits

WellCare's information-delivery system supports the foundation of our approach to managed care with the accurate and timely capture, processing, and analysis of critical operational data. We are a data-driven organization that uses data-based decision making to operate our business in a responsible, cost effective manner. WellCare customizes reporting for each state in which we operate, and we have extensive experience in providing a wide variety of reports for external monitoring purposes. Above all, WellCare understands the need for data in the monitoring and quality assurance process.

In order to make our data readily available to the State and to promote transparency of our operations, WellCare has developed several methods to transfer data to our State clients in a timely manner. We can distribute reports by PGP-encrypted email, secure FTP, or through our web site. WellCare has also designed a Web-accessible portal in Georgia that allows State staff to access reports, documentation, and performance metrics.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

WellCare uses a variety of data sources and reporting capabilities to measure our performance. Performance is measured at the state level, and then compared within and across states by WellCare staff. Following are some of the performance related data we collect and monitor, and how results are used to improve and maintain our performance.

- **HEDIS audits and CAHPS member satisfaction surveys** are conducted on an annual basis. HEDIS is used to measure health plan performance in clinical areas and to identify opportunities for clinical quality improvement. The results of the CAHPS survey are reviewed by The Customer Service Quality Improvement Work Group to determine the root cause for low scores and to recommend changes in work flows and/or processes to improve the customer satisfaction scores. The work group continues to monitor the scores regularly to ensure that the changes that were made adequately impact customer satisfaction.
- **Member services** are monitored through regular grievance tracking and customer service call inquiry tracking, in addition to the CAHPS survey, as described above. For the call center, hold times and call abandonment rates are monitored on an ongoing basis to assure adequate access to customer services for members and providers. Questions/topics of call center calls are also tracked. Grievances are monitored by the Appeals and Grievances Committee, which is overseen by the Medical Director. The Committee makes recommendations based on grievances to be incorporated into WellCare's ongoing quality improvement strategy.
- **Access and availability** is monitored yearly, and as required to assure adequate provider accessibility for our members. The GeoAccess report evaluates member-driving distance from PCP, Specialists, Ancillary Providers and hospitals, and evaluates access for members to available providers in the network. The report is reviewed by the MAC and the QIC. In addition, appointment wait times and other access measures are monitored through the Customer Satisfaction Survey on a yearly basis.
- **Provider satisfaction** is monitored on an ongoing basis by regular contacts between providers, their office staffs, and Provider Relations representatives. This frequent contact by field staff helps identify local issues affecting provider satisfaction so that the plan can develop interventions, trainings, etc., to overcome any identified points of abrasion. The provider network is surveyed on an annual basis and as needed to assess provider satisfaction with WellCare.
- **Claims payments** are monitored through our data warehouse and reporting system, Perot System's Diamond 950 software, an enterprise software solution developed specifically for health plans. Its integrated database architecture helps to assure that consistent sources of claims and member

information are provided across all of our health plans. We use our systems for premium billing, claims processing, utilization management, reporting, medical cost trending, planning, and analysis. The system also supports member and provider service functions, including enrollment, member eligibility verification, primary care and specialist physician roster access, claims status inquiries, and referrals and authorizations.

- **Provider profiling** is conducted for all PCPs and certain high-volume specialists such as OB/GYNs. The performance measures included in the profile reports will include HEDIS measures relevant to primary care such as child health check-ups, adolescent immunization rates, asthma medication management, diabetes management, chlamydia screening, and cervical cancer screening. OB/GYN reports will include analyses of prenatal and postnatal care. Reports will be produced quarterly to show utilization rates on a per 1,000 member basis, with comparisons to the PCP's membership roster and the overall plan membership. In addition to sharing this quarterly report with providers, PCPs are also provided with monthly reports indicating which patients are not in compliance with preventive care scheduling guidelines.
- **Financial Reporting** is conducted regularly to ensure WellCare meets or exceeds regulatory financial measures and surpluses. We obtain an unqualified annual audit opinion of our financial statements and seek continuous improvement in our Standard and Poor's and Moody's ratings. Contract awards, such as that in Georgia, are further recognition of our financial strengths.
- **Utilization** (including under utilization and over utilization) is monitored through a number of reports, including Daily Census, Monthly Inpatient Utilization Reports, Pharmacy Reports, Physician Profiling, Medical Record Review, Physician Risk Group Reports, and Reduction of ER Use for Non Emergency Services.
- **Enrollment and Disenrollment rates** are monitored regularly to determine attrition rates and growth in membership. If high attrition is detected, we identify root causes, look for correlations with external and internal factors, and take any needed corrective action. WellCare also monitors other important member metrics such as timely delivery of ID cards and member hotline performance.

I. Net Worth and Restricted Deposit Requirements

In addition to the statutory net worth and restricted deposit requirements for HMOs, TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56-32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of $900,000 plus specified amounts of premium revenue in excess of $20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute. If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

Net worth and depositing requirements are not a deterrent to contracting with TennCare. WellCare encourages TennCare to adopt a National Association of Insurance Commissioners guideline of 200 percent risk based capital. We believe this level appropriately mitigates State risk while avoiding excess

reserves that restrict an MCO's cash. WellCare also recommends that MCOs have contractual flexibility to meet this standard with a combination of a performance bond, letter of credit, or parental guarantee.

J. Implementation Timeframe

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

We believe this timeframe is overly ambitious and will not be in TennCare's best interests. See comments below.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

An extremely narrow gap between release date of the RFP and the due date for proposal submission would likely have the effect of restricting the field of interested applicants, and would make it particularly difficult for organizations not yet serving TennCare enrollees (such as WellCare) to bid. Network development is the most significant activity that warrants time consideration. Therefore, we recommend that there be a minimum 90 day timeframe between the RFP's issuance and the proposal submission date. If the RFP is released in January, this would mean responses would be received by the State in April. We would urge that the State allow itself two months to complete its review of the proposals and to negotiate contracts with the selected MCOs.

If awarded a contract, WellCare is able to dedicate vast resources to the TennCare implementation in order to bring the program into operations as soon as possible. Nonetheless, our experience is that several months are needed from the date of contract award to the effective date of initial enrollment. We further recommend a six-month implementation timeframe for the selected MCOs, with enrollment beginning in January 2007. This will allow sufficient time for the following implementation activities:

- testing of file transfers between MCOs, the fiscal agent, and enrollment broker for enrollment, prior authorization, claims history and other data files;
- review of MCO policy and procedures, staffing and training plans, and marketing materials;
- resolution of any issues, details, or policy changes; and
- readiness reviews.

When more rapid timelines are used, full testing of IT interoperability may not occur. Should there be issues upon implementation, these areas can cause greatest operational difficulty for members and providers. It is in the State's best interest to ensure smooth implementation.

Clarifying Questions

In developing this response to the RFI, we have the following outstanding questions. Please consider these as you develop the final RFP.

1. The RFI states (on page 9), "Through a series of Circuit Court reversals of the local federal judges, the State has sought and achieved relief on some of the most onerous provisions of its various consent decrees." Please provide specific information in the RFP on each provision of these consent decrees (whether or not they have been changed recently). For each provision, what changes have been sought by the TennCare Administration? What changes in the rulings resulted? What are the anticipated cost impacts of such changes?
2. The RFI states (on page 10) that "The administration has committed to reopening this program [covering non-pregnant medically needy adults] by July of 2006." Please describe how rates will be set for this eligibility category. One could reasonably expect, for example, that the medically needy persons who were able to retain coverage (and for whom data exist to establish baseline costs) will, on average, have much lower monthly claims costs than those who choose to come forward to obtain coverage. Those who come forward are particularly likely to do so at the point of needing/using costly services, at which point the provider faces a bad debt and/or the patient faces an enormous bill. Please provide specific enrollment and payment rate impacts associated with whatever eligibility expansions are anticipated.
3. What provisions exist around care rendered by out-of-network providers? Is there an underlying fee-for-service (FFS) Medicaid rate schedule that applies in these situations? Are providers able to bill for charges? If there are no such provisions in place, we encourage that the State set forth the out-of-network payment provisions that MCOs and providers need to abide by – otherwise the system is set up to create costly and unpleasant haggling over each claim by all involved parties. On a related note, Georgia implemented a policy whereby if an MCO could document that it offered to include the provider in its network at a payment at least equal to the Medicaid fee-for-service rate, and the provider opted not to join the network, the MCO would be responsible to pay only 90 percent of the Medicaid FFS rate to that provider for out-of-network services rendered to its members. This provision was effective in helping plans establish provider networks and avoid a situation where providers could "just say no" to the managed care initiative with little repercussion and with freedom to seek full charges for Medicaid patients. Such mechanisms are important in including, at a fair payment level, providers who enjoy a "monopoly" position in a given service area.
4. Regarding the cost-sharing provisions in the RFI (page 15), will MCOs be responsible for collecting premiums for TennCare Standard enrollees? Also, on the co-payments, are the eligibility categories clearly defined such that an MCO can readily discern which FPL tier an enrollee belongs to (such that the appropriate co-pay can be charged)?
5. Please provide more detail on the shared risk arrangement that has been implemented effective in July, 2005. We are hopeful that a document is already available that sets forth the full details of this arrangement.
6. For each of the screening rates used to assess quality performance in the disease management and EPSDT arenas, please provide all available information on screening rates in the TennCare program in the Middle Region and in other regions during the past 2-3 years.